SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

PAST DUE PAYMENT AGREEMENT

ACCOUNT NAME: _____

ACCOUNT NUMBER(S): _____

I, (Responsible Party), recipient of care and maintenance bills for (person's name), hereby agree to the following terms for payment of (person's name) past due care and maintenance charges. I will pay ($amount) per month for (number of months) with the final payment of (final payment $amount) being due (mm/dd/yy). I understand this is to be paid in addition to normal monthly care and maintenance charges.

The first payment is due (mm/dd/yy). Each subsequent monthly payment is due by the 20th day of each month until paid in full. I understand that if I fail to make payments of the additional amounts stated above, the full amount of the outstanding balance must be paid in full upon receipt of notice that this agreement is in default. (Default occurs when a payment is not received within 30 days of the due date.)

Parent/Responsible Party	Date
Regional Claims and Collection Officer	Date
Regional Facility Administrator	Date
Chairman, Accounts Receivable Review Committee	Date